Nursing Oversight and Care Management Nursing Care Plan
*Note: please use the second page for any information that does not fit into the columns on the first page. Use extra pages as necessary

Name: _____ Date of Birth: _____

NOCM Nurse: _____ Care Coordinator: _____

Primary Physician: _____ Primary Med. Dx: _____

Medications: _____

Equipment/technology/assistive devices: _____

Diet/activities/other: _____

Level of Self Care Key	0	1	2	3	4	5
	Completely Independent	Requires Use of Assistive Device	Needs Minimal Help	Needs Assistance and/or Some Supervision	Needs Total Supervision	Needs Total Assistance or Unable to Assist

NURSING DIAGNOSIS	GOAL	INTERVENTIONS	EVALUATION/OUTCOME
		Level of Self Care: _____	
		Level of Self Care: _____	
		Level of Self Care: _____	
		Level of Self Care: _____	
		Level of Self Care: _____	

_____ _____

Date Signature

Additional Information/Comments: